MDR Tracking Number: M5-04-3891-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 7-13-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that Levels III and IV office visits, therapeutic exercises, joint mobilization, neuromuscular reeducation, myofascial release and manual therapy technique form 7-28-03 through 9-17-03 were not medically necessary. Therefore, the requestor is not entitled to a reimbursement of the paid IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were not the only fees involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 9-17-04 the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Regarding CPT code 99213 for dates of service 8-7-03, 8-26-03 and 8-27-03: Review of the requester's and respondent's documentation revealed that neither party submitted copies of EOB's. There is no "convincing evidence of the carrier's receipt of the provider request for an EOB." according to 133.307 (e)(2)(B). No reimbursement is recommended.

This Finding and Decision is hereby issued this 19th day of November , 2004.

Donna Auby

Medical Dispute Resolution Officer
Medical Review Division
Enclosure: IRO Decision

November 9, 2004

Ms. Rosalinda Lopez
Texas Workers Compensation Commission
MS48
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

NOTICE OF INDEPENDENT REVIEW DECISION
Corrected Letter

RE: MDR Tracking #: M5-04-3891-01
TWCC #:
Injured Employee:
Requestor: Tarrant County Chiropractic & Rehabilitation
Respondent: Texas Mutual Insurance
MAXIMUS Case #: TW04-0385

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to MAXIMUS for independent review in accordance with this Rule.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the MAXIMUS external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The MAXIMUS chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to MAXIMUS for independent review. In addition, the MAXIMUS chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a male who sustained a work related injury on ___. A MRI of the lumbar spine performed on 7/15/02 indicated moderately severe spinal stenosis at L4-5, severe degenerative facet and ligamentum flavum hypertrophy coupled with mild, 1mm, annular disc bulging, dehydration with 3mm posterocentral disc protrusion in the L2-3 disc, possible annular fissure, dehydration with 1mm annular disc bulge in the L1-2 disc, dehydration with 2mm disc protrusion in the central and right paracentral portion of the L5-S1 disc, and multilevel bilateral degenerative facet hypertrophy. The diagnoses for this patient have included lumbar disc displacement and mylagia and myositis, nos. On 2/6/03 the patient underwent a right iliac crest bone graft, allograft L4, L5, S1, laminectomy, bilateral foraminotomy, left transforaminal lateral interbody fusion of L4, L5, and S1 with Devex cages, posterior spinal fusion L4-S1, and somatosensory evoked potential monitoring. Postoperatively the patient was treated with rehabilitation.

Requested Services

Levels III & IV office visits, therapeutic exercises, joint mobilization, neuromuscular reeducation, myofascial release, manual therapy technique from 7/28/03 through 9/17/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Rehab Sheet 7/28/03 –1/13/04
2. Neuromuscular Reeducation Sheet 8/27/03-1/13/04
3. Office Notes 7/28/03 – 9/17/03
4. MRI report 7/15/02
5. Comparative Muscle ROM test 7/30/03
6. Operative Note 2/6/03

Documents Submitted by Respondent:

1. No documents submitted

Decision

The Carrier's denial of authorization for the requested services is uphel.

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this case concerns a 51 year-old male who sustained a work related injury on ___. The MAXIMUS chiropractor reviewer indicated that on 2/6/03 the patient underwent surgery for degenerative disc disease, joint disease and degenerative spinal stenosis of the lumbar spine. The MAXIMUS chiropractor reviewer noted that the patient began postoperative physical therapy and rehabilitation on 6/9/03. The MAXIMUS chiropractor reviewer indicated that an evaluation note dated 7/28/03 described findings that included decreased lumbar ranges of motion, sensory changes and several positive orthopedic tests and indicated the diagnoses of lumbar disc displacement and myalgia and myositis. The MAXIMUS chiropractor reviewer noted that the patient received therapeutic exercises, mobilization, neuromuscular reeducation, myofascial release and manual lymphatic drainage or manual traction throughout care. The MAXIMUS chiropractor reviewer indicated that the patient began the exercise and therapy program on 7/28/03. The MAXIMUS chiropractor reviewer explained that for medical necessity to be established, there must be an expectation of recovery or improvement within a reasonable and generally predictable time frame. The MAXIMUS chiropractor reviewer indicated that the type, frequency and services must be reasonable and generally predictable with standards of practice in the chiropractic community. The MAXIMUS chiropractor reviewer explained that additional treatment would be necessary if objective benefit can be demonstrated. The MAXIMUS chiropractor reviewer also explained that there is no indication in the documentation provided that the patient had received any significant lasting objective benefit. The MAXIMUS chiropractor reviewer indicated that there is no evidence of progress examinations or recent test results to measure objective benefit. The MAXIMUS chiropractor reviewer explained that the patient had not responded to care or received any lasting benefit from treatment or that the care had changed the treatment outcome. The MAXIMUS chiropractor reviewer also explained that the Mercy Guidelines calls for a short

course of care consisting of two weeks each for a total of four weeks of two different manual procedures. The MAXIMUS chiropractor reviewer further explained that without documented improvement, manual procedures are no longer indicated. Therefore, the MAXIMUS chiropractor consultant concluded that the Levels III & IV office visits, therapeutic exercises, joint mobilization, neuromuscular reeducation, myofascial release, manual therapy technique from 7/28/03 through 9/17/03 were not medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department